

drug-dose combination was calculated in 2006 dollars and was compared to prices available through the November 2006 FSS. A savings/pill was calculated to develop a nationally representative estimate of the societal savings that could be achieved if medications could be obtained for FSS prices instead of current pricing systems. **RESULTS:** Substitution of the FSS price could result in a median annual per person savings in drug expenditures of \$308 (interquartile range, \$124 to \$637) for the Medicare population, age 65 and above. The potential national savings among these 8 classes over one year is \$10.7 billion (95% CI \$10.0 billion to \$11.4 billion). Among Statin medications alone, the annual savings could be \$5.9 billion (95% CI \$5.4 billion to \$6.4 billion) in this age group. **CONCLUSION:** Substantial savings in drug expenditures, in the tens of billions of dollars, would result if Federal Supply Schedule prices were used by Medicare in place of these commercially available prices.

MD2**PER-PATIENT-PER-MONTH DRUG COSTS IN MEDICARE PART D PROTECTED CLASSES**

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OBJECTIVES: The objective of this study was to estimate per patient per month (PPPM) costs of medications in the six Medicare Part D protected classes based on findings among Medicare and dual eligible beneficiaries with drug coverage prior to enactment of the benefit. **METHODS:** Data were from the Thomson Medstat Marketscan Medicare and Medicaid claims databases. The study sample was constructed by identifying patients who were enrolled either in Medicare or dually in Medicare and Medicaid in 2004. Costs were aggregated within each class, including patient-paid and plan-paid amounts. These costs provided the numerators for the PPPM calculations. Denominators were defined as the aggregated patient months for only those individuals who filled a drug within a particular class. Drugs covered under Part B were excluded. **RESULTS:** The classes where generic formulations were available (antidepressants and anticonvulsants) showed lower PPPM costs (\$45.31 and \$50.97, respectively). The costliest class was the antiretrovirals (\$1028.13) for dual eligible patients including those age 64 and under. Among the dual eligibles over 65, immunosuppressants were the costliest (\$657.72). In the Medicare group, the cost of immunosuppressants (\$814.86) was substantially higher than the other five classes. The PPPM cost over all 6 classes for Medicare was \$54.75, for dual eligibles it was \$157.99, and \$116.35 for all patients. **CONCLUSION:** PPPM costs were not uniformly high among the protected classes. The claims data in this study allowed a “real world” check of how much the protected classes may impact the finances of Part D. There are differences within the classes between the dual eligible and Medicare patients, and also within the dual eligibles by age. This is an important message to policy makers that a change to the structure of the protected classes in Part D may have differential effects across and also within classes.

MD3**CHANGES IN PRESCRIPTION USE AND OUT-OF POCKET COSTS AMONG MEDICARE ELIGIBLE ADULTS, 2005–2006**

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OBJECTIVES: Few assessments of the Medicare Part D Prescription Drug Benefit have been performed. We examined the

impact of the drug benefit on drug utilization and out-of-pocket expenditures. **METHODS:** We used pharmacy claims data from a large national pharmacy to compare drug utilization and out-of-pocket expenditures of Medicare eligible seniors in 2005 to their outcomes in 2006. We used pharmacy customers aged 60–64 during the same period as a control group to capture non-Medicare related trends in drug utilization and costs occurring during the study period. The sample represented approximately 5.1 million unique Medicare beneficiaries aged 65–90 and 1.8 million unique subjects in the control group who filled and obtained at least one prescription in pre-benefit 2005 period. **RESULTS:** After adjusting for individual characteristics and socio-economic characteristics of subjects' zip code of residence, preliminary analyses suggest subjects' annual drug utilization increased by 5.5% (95% confidence interval [CI] 4.7%–6.2%) and subjects' annual out-of-pocket expenditures decreased by 10.6% (CI 9.6%–11.9%) in 2006 as compared to 2005, net of non-Part D related effects. Dual eligible subjects had little to no increase in drug utilization. However, they had similar declines in out-of-pocket expenditures as the broader beneficiary population. Sensitivity analyses demonstrated that the measured impact was not due to trend differences among different age groups over the study period. **CONCLUSIONS:** Modest increases in prescription drug utilization and decreases in out-of-pocket expenditures occurred for these Medicare seniors following the implementation of the Medicare Part D Prescription Benefit. Further work is needed to examine these patterns among other beneficiaries and to evaluate the impact of these changes on health outcomes.

MD4**MEDICAID PREFERRED DRUG LISTS' COSTS TO PHYSICIANS**

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OBJECTIVES: To measure costs from complying with Medicaid preferred drug lists (PDLs) for primary care physicians and cardiologists. To quantify the potential costs of a hypothetical universal PDL for Medicare Part D as of January 2006. **METHODS:** During December 2005 and January 2006 we surveyed cardiologists and primary care physicians in 9 states about their experiences with Medicaid PDLs that covered outpatient prescriptions for statins and antihypertensives. We calculated the opportunity cost of time spent by physicians and their staff on requesting prior authorizations (PAs), appealing rejected PAs, discussing PDLs with others, tracking changes to PDLs, and receiving PDL-related training, as well as physicians' altruistic costs from suboptimal prescribing decisions. We used comprehensive prescription data from Wolters Kluwer Health (WKH) to generate each physician's annual prescription volume for statins and antihypertensives separately by PDL coverage status. We combined the survey data on PDL-related costs per physician with the WKH prescription volume data using a bootstrap simulation to calculate total costs and the average cost per physician. We calculated the potential costs of a hypothetical universal Medicare Part D PDL by approximating the number of new Part D prescriptions affected by PDLs and multiplying by the survey-based average variable cost per prescription. **RESULTS:** There were 986 survey respondents and 47,843 physicians with WKH data. For statins and hypertensives, PDL cost per prescription averaged \$8.02 (95% CI: \$7.25–\$8.78)—\$14.41 (95% CI: \$13.29–\$15.53) off-PDL and \$6.59 (95% CI: \$5.91–\$7.28) on-PDL—leading to average Medicaid PDL costs per physician of \$1110 (95% CI: \$1061–\$1161) annually. Similar restrictions for Medicare Part D across all therapeutic classes could have cost